A "Medical Grange" for Malpractice Insurance

TO THE EDITOR: The Medical Grange—a system for survival in the malpractice insurance crisis?

Professional liability coverage, in the form of insurance, is an invitation to a suit. Malpractice attorneys and juries tend to regard insurance as an amorphous pot of gold. Since the doctor has already placed the money into the pot, they reason, he isn't being hurt when it is drained. No matter who the owner is—be it Travelers, Argonaut or even the CMA—this concept of an insurance pot will not change. Somehow we must find an alternative to professional liability insurance which will protect physicians from serious economic loss, be reasonably priced to avoid a fee increase and allow the injured patient to be compensated adequately. All this with no consideration to the effects of legislative reform, as it may well be two to five years before such reforms become law.

By reviewing how the professional liability insurance premium is spent, we can perhaps determine a *new* approach to liability protection.

1. Insurance company overhead—34 percent. This pays the salaries, taxes and profits of the company. CMA-sponsored insurance may be able to reduce this to 25 percent, which is hardly a savings. So, we eliminate the insurance company completely by *canceling our insurance.*

2. Defense attorney fees—38 percent. Most suits are not based on malpractice incidents, yet *all* must be defended. Under the current system, it frequently takes years to settle the suit, with defense costs rising as the legal chess game continues. The answer here is twofold: (a) binding arbitration agreements with our patients and (b) a group coverage system with a $10,000 deductible feature.

Binding arbitration has been shown to be effective in eliminating nuisance suits' costs. Rapid arbitration settlement promotes greater patient satisfaction and lessens the tendency to seek vindictive and punitive awards. The $10,000 deductible clause would take the bulk of the defense attorney fees off the shoulders of the group and place it directly upon the doctor being sued. Almost all doctors can afford a $10,000 loss, but cannot afford the $50,000 or $1,000,000 settlement. We need protection in the area *over* $10,000 and really not below that amount.

Therefore, by eliminating the insurance company (34 percent), and by reducing and moving defense fees (38 percent) to the pocket of the defending physician, we have eliminated 72 percent of the cost of the professional liability coverage. The remaining 28 percent goes to patients (16 percent) and their attorneys (12 percent).

In tribute to the early West when mutual protective groups were mandatory for survival, this concept can be called the Medical Grange. Here is how such a group could work:

1. Carefully select one thousand (1,000) physicians with similar attitudes to quality medical practice and with a minimum of bad risk practices.

2. Each Grange member would cancel his professional liability insurance, and notify his patients of the same, and secure binding arbitration agreements. Patients do prefer binding arbitration to a 25 to 35 percent increase in medical fees.

3. Each physician will pledge to his fellow Grange members to establish and maintain a $10,000 self-defense fund in his own name and control. This self-defense fund would be his deductible amount to be used only for defense attorney fees or awards. Each year the physician would add another $2,000 to his self-defense fund until it reached $20,000.

4. At the start of the program each of the one thousand physicians would contribute $4,000 apiece as a performance bond to the Grange fund. This fund of $4,000,000 would be invested at 8 percent interest, and the $320,000 interest would pay the salaries of the administrator, clerical staff, meetings, publications, correspondence and the retaining fees of the defense counsel. Every year each Grange member would add another $1,000 to the Grange fund.

5. When a member is successfully sued, he would pay the first $10,000 of costs and awards and the remainder would be spread out over the group of one thousand. This assessment would be prorated according to the risk of the specialty of the individual member. If a member failed to pay his assessment within a given period of time, he would lose his Grange membership and coverage and the assessed amount would be subtracted from his performance bond.

6. If and when less expensive malpractice insurance becomes available, that is, via national health insurance, the Grange fund will be returned to the members and the Grange will be dissolved.

In 1974 among 40,000 physicians in California, $34,000,000 was awarded to the patients and

their attorneys. This is the 28 percent of the premium dollar. Assuming that awards do not decrease and that the one thousand Grange members have average performance and risk, the cost to the individual non-sued member would have been $850. This is a far cry from the premiums most of us pay at the present time.

Undoubtedly, there are many aspects of this Grange concept that need to be clarified and solved. But the legal framework *can* be developed. It is time that we explore *all* alternatives, and there is no reason that physicians themselves cannot develop a new system. Do we have to wait for someone else to do what we need done for ourselves? I would enjoy your comments and suggestions.

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Diabetic Microangiopathy

TO THE EDITOR: It has come to our attention that in a Medical Staff Conference on Diabetic Microangiopathy (West J Med 121:404-412, Nov 1974) Dr. Marvin Siperstein took rather questionable liberties with the statistics of data published by Dr. Paul Beisswenger and one of the undersigned (R.G.S.) on the composition of diabetic glomerular basement membrane.[1]

Dr. Siperstein claimed that the observation of a statistically significant elevation ($P<0.01$) of the hydroxylysine content of diabetic basement membranes depends entirely on the highest point in the group of eight diabetic cases and that omission of this point leads to a nonsignificant P value.

A careful statistical reanalysis of these data has indicated that Dr. Siperstein's contentions are unfounded and incorrect. The highest value of the diabetic cases does not meet the criteria for an "outlying observation"[2] and therefore can not be rejected. Indeed even when this highest number is excluded, a comparison of the normal and remaining diabetic cases still shows a significant difference ($P<0.02$). If Dr. Siperstein had been motivated to leave out the lowest rather than the highest diabetic point, which is equally unjustifiable, a P value of less than 0.005 between the two groups would have been obtained.

In a further attempt to detract from the data, Dr. Siperstein indicated that five of the eight diabetic cases are within normal limits ($\pm 2SD$). In fact this observation has no adverse implications since it only indicates that the groups overlap. Such overlapping frequently occurs between different groups, but it is the standard error of the mean which is utilized in determining whether or not the samples come from a single or two distinct populations.

In his presentation Dr. Siperstein fails to mention the additional compositional changes observed in the diabetic glomerular basement membrane[1] such as the decrease in lysine ($P<0.001$), increase in glucose ($P<0.01$) and increase in galactose ($P<0.001$).

The question of the relationship of control to the microvascular complications is one which is of great importance to practitioners and researchers in the field of diabetes. There is no general acceptance of Dr. Siperstein's statement that "It is now apparent to everyone who follows diabetic patients that these manifestations of diabetes progress rather inexorably, regardless of the degree of control." It is unfortunate that in his zeal to advance his point of view, Dr. Siperstein finds it necessary to distort not only this work of Beisswenger and Spiro but also the distinguished contributions of Williamson and of Bloodworth and Engerman.

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REFERENCES

1. Beisswenger PJ, Spiro RG: Studies on human glomerular basement membrane—Composition, nature of the carbohydrate units and chemical changes in diabetes mellitus. Diabetes 22: 180-193, Mar 1973
2. Grubbs FE: Procedures for detecting outlying observations in samples. Technometrics 11:1-211, 1969

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The Author Replies

TO THE EDITOR: In my grand rounds of January 9, 1974 on diabetic microangiopathy [Medical Staff Conference. West J Med 121:401-412, Nov 1974], I discussed, and tried to put into perspective, the finding of an increase in hydroxylysine in diabetic basement membranes, which has been reported by Drs. Beisswenger and Spiro.[1,2] In their writings, Dr. Spiro and Dr. Beisswenger have emphasized that they have found "marked" and "consistent" increases in the *hydroxylysine* con-